IDAHO DEPARTMENT OF
HEALTH & WELFARE

JAMES E. RISCH – Governor
RICHARD M. ARMSTRONG – Director

DEBBY RANSOM, R.N., R.H.I.T – Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, Idaho 83720-0036
PHONE: (208) 334-6626
FAX: (208) 364-1888
E-mail: fsb@idhw.state.id.us

June 20, 2006

FILE COPY

Pat Gooding, Administrator
Kuna Living Center
194 W White Way
Kuna, ID 83634

Dear Ms. Gooding:

On June 12, 2006, a complaint investigation survey was conducted at Kuna Living Center. The survey was conducted by Patrick Hendrickson, R.N. and Frutoso Gonzalez, R.N. This report outlines the findings of our investigation.

Complaint # ID00001329

Allegation #1: On April 29, 2006 at 5:00 p.m. Building 1 was 85 degrees. Staff had instructed the evening staff to open the doors and windows to try to cool the building off. At 4:30 p.m. the owner visited the facility and turned down the thermostat but refused to turn on the air conditioner. A resident became over heated and his daughter took him out of the facility until 11:00 p.m.

Findings: Based on observation, interview and record review it was determined that on April, 29, 2006 the facility documented the outside temperature was 85 degrees. The temperature in Building 1 was not documented. On April, 29, 2006 at 5:30 p.m., the administrator documented the thermostat setting for the air conditioner was at 74 degrees. The identified resident left the facility on April, 29, 2006 with his daughter and returned to the facility later that evening.

On June 12, 2006 the thermostat for Building 1's heating and cooling unit was set for 74 degrees cool and 72 degree heat. The indoor building temperature was 75 degrees.

Review of the facility's complaint log revealed that on April, 29, 2006 the identified resident complained the facility was hot. Further review of the complaint investigation revealed a heating and air conditioner contractor came to the facility to inspect the heating and cooling units and that they were operational.

On June 12, 2006 at 1:50 p.m., the identified resident's room was toured. His window was closed and his room was cool. He said he occasionally opened the window but he was comfortable with the temperature of his room.

On June 12, 2006 between 2:15 p.m. to 3:00 p.m., six random residents stated the facility temperature was comfortable.

On June 12, 2006 at 2:30 p.m., the administrator stated she was aware a resident had complained the facility was hot. She said when she arrived to the facility on April, 29, 2006 the resident had opened his window. She stated the other residents in the building stated they were comfortable with the building temperature. She said she had contacted a heating and air conditioning repair person to come to the facility and ensure the air conditioner was functioning properly. She said the air conditioner was functioning properly.

Conclusion: Substantiated. The facility was not issued a deficiency was they acted appropriately by contacting a heating and air conditioning contractor to check the heating and cooling unit.

Allegation #2: Residents complained they did not receive enough to eat. When residents asked for seconds there was not enough food to meet these requests.

Findings: Based on observation and interview it was determined that residents received enough food to eat. Residents were offered seconds and there was enough food to meet these requests.

On June 12, 2006 there was observed to be seven days worth of non-perishable and three days worth of perishable food in the facility pantry and refrigerator. Additionally, snacks were available for residents.

On June 12, 2006 at 2:00 p.m., the facility's cook stated she prepared meals and snacks for the residents. She ensured to prepare enough food so there was plenty available for resident's that want seconds or for visiting families who may want to eat.

On June 12, 2006 between 1:50 p.m. and 2:20 p.m., five random alert residents stated that meals were substantial and they are offered seconds when requested.

On June 12, 2006 at 2:20 p.m., a family member stated that meals were substantial and the facility offered seconds if requested by residents.

On June 12, 2006 at 2:30 p.m., the administrator stated she was not aware of an instance where residents did not get enough food or were denied snacks. She said the cooks prepared enough food to provide seconds if requested by residents.

Conclusion: Unsubstantiated. Although it may have occurred, it could not be determined during

the complaint investigation conducted on June 12, 2006.

Allegation #3: The administrator was verbally abusive to residents, i.e., scolding and threatening to discharge them if they complain to the ombudsman or the state survey agency.

Findings: Based on interview it was determined the administrator was not verbally abusive to residents.

On June 12, 2006 between 1:50 p.m. and 2:20 p.m., five random alert residents stated the administrator treated them and spoke to them in a manner that showed dignity and respect.

On June 12, 2006 at 2:10 p.m., a caregiver stated the administrator spoke to the residents in a manner that showed dignity and respect.

On June 12, 2006 at 2:20 p.m., a family member stated the administrator treated and spoke to the residents with dignity and respect.

Conclusion: Unsubstantiated. Although it may have occurred, it could not be determined during the complaint investigation conducted on June 12, 2006.

Allegation #4: A resident went 4-5 hours without being toileted and her peri area was red and raw. Her urine had a foul odor but the facility refused to contact the resident's physician.

Findings: Based on interview and record review it was determined the identified resident did not go 4-5 hours without being toileted. Further her peri area was not reported as being red and raw, and her urine was not reported as being foul and odorous, nor did the facility refused to contact the residents physician.

Review of the identified resident's negotiated service agreement dated October 12, 2005 on June 12, 2006 revealed documented evidence the resident needed extensive assistance with toileting and staff were to help direct the resident to wipe and wash. Further the NSA documented the resident often refuses cares.

Review of the resident's record revealed progress notes dated January 4, 2006 through April 16, 2006 that documented the resident would refuse cares. There was no documentation that the resident went 4-5 hours without being toileted. There was no documented evidence that her peri area was red and raw.

The resident's record also contained nursing assessments from March through June 2006 that documented the resident did not have a red and raw peri area. Additionally, the resident's urine did not have a foul odor.

On June 12, 2006 at 2:40 p.m., a caregiver stated the resident was incontinent of urine and that she offered to toilet the residents every two hours or as needed. She said the resident did refuse cares at times. She stated she was unaware of a time the resident's urine had a foul odor. She said the resident had and order for A and D ointment to be

used for a red and raw peri area but she has never had to use it.

On June 12, 2006 at 2:50 p.m., the identified resident stated she was offered assistance to toilet every two hours or as needed and that she did refuse to go to the toilet at times. She denied that her urine had a foul odor or that she had a red and raw peri area.

Conclusion: Unsubstantiated. Although it may have occurred, it could not be determined during the complaint investigation conducted on June 12, 2006.

As no deficiencies were cited as a result of our investigation, no response is necessary to this report. Thank you to you and your staff for the courtesies extended to us on our visit.

Sincerely,

Patrick Hendrickson
Team Leader
Health Facility Surveyor
Residential Community Care Program

PH/slc

c: Virginia Loper, R.N., Supervisor, Residential Community Care Program